UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

CAYUGA MEDICAL CENTER
AT ITHACA, INC.

Cases 03-CA-185233
and 03-CA-186047

1199 SEIU UNITED HEALTHCARE
WORKERS EAST

GENERAL COUNSEL'S ANSWERING BRIEF TO RESPONDENT'S EXCEPTIONS TO THE ALJ DECISION

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GENERAL COUNSEL'S ANSWERING BRIEF[1]

It is respectfully submitted that in all respects, the findings of the ALJ are appropriate, proper, and fully supported by the credible record evidence. The evidence clearly demonstrates Respondent is motivated by anti-union animus in discharging its employees.

I. Preliminary Statement

The ALJ found Respondent violated Section 8(a)(1) and (3) of the Act by suspending and discharging its employees Anne Marshall and Loran Lamb and that it violated Section 8(a)(1) of the Act by removing union literature from its bulletin boards. (ALJD 52:45-53:7).[2]

In its Brief in Support of Exceptions, Respondent theorizes that the ALJ erroneously reached the conclusion that Respondent violated the Act because she somehow developed a "theory" that Respondent's discharge of RNs Loran Lamb and Anne Marshall because of the September 11, 2016 blood transfusion incident was a "ruse" to get rid of the lead union supporter at Respondent's facility. Contrary to Respondent's assertions, the ALJ obviously did not fabricate a baseless "theory" – General Counsel proved, and the record clearly reflects, that Respondent's actions in response to the blood transfusion incident were atypical, and Respondent showed such animus toward union activity, specifically lead employee organizer Anne Marshall's union activity, that it suspended and discharged her when it otherwise would not have, and suspended and discharged Loran Lamb to give cover to its unlawful actions toward Marshall.

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[1] Pursuant to Section 102.46(d)(1) of the Board's Rules and Regulations, Counsel for the General Counsel hereby submits this Answering Brief in response to Respondent's Exceptions to the Decision and Recommended Order of Administrative Law Judge Kimberly Sorg-Graves (ALJ) dated January 8, 2018, in the above-referenced cases.

[2] References to the ALJ's Decision shall be designated as (ALJD ___:___) showing the page number first followed by the line numbers; to the Respondent's Brief as (R. Br. __) where the blank is the page number; to the transcript as (Tr. __); to the General Counsel's Exhibits as (GC Exh. ___); and to the Respondent's Exhibits as (R. Exh.___).

A. Background of union organizing at Cayuga Medical Center

In about April 2015, Respondent's nurses, with Marshall its undisputed leader, began a campaign for representation by 1199 SEIU United Healthcare Workers East (Union). Marshall remained the lead organizer among employees until her unlawful termination on October 6, 2016. In response, Respondent, as found by the Board in *Cayuga Medical Center at Ithaca, Inc.*, 365 NLRB No. 170 (2017), committed numerous unfair labor practices in violation of Section 8(a)(1) and (3) of the Act, including disciplining and demoting Marshall because of her union activity.[3] Despite Respondent's unlawful actions toward her, Marshall continued to vocally support the Union. Respondent, apparently steadfast in its belief that the NLRB exhibits a "complete union bias" and that the ALJ in the prior case was an "activist judge,"[4] continued its pattern of unlawful actions toward Marshall because of her union activity when it suspended and discharged her, along with Lamb, and yet again removed pro-union flyers from its bulletin boards.

B. Respondent's blood transfusion policy

The ALJ gave a detailed explanation of Respondent's blood transfusion policy, the blood transfusion cards nurses are required to fill out, and the medical records that reflect that nurses have followed the required procedure. (ALJD 7:30-10:37). Although the blood transfusion policy is several pages long, the ALJ noted that Respondent contends that Marshall and Lamb were discharged for violating the following steps:

[3] That case, 365 NLRB No. 170, is currently pending before the Second Circuit.
[4] (ALJD 19:42-19:45, Tr. 1017, GC Exh. 23).

12. A two-tier verification should be implemented on inpatient floors:

A) Before taking blood into the patient room, the two nurses must verify the blood against the order and chart for correct patient name, blood type, type of blood product. No product should enter the patient room until it is verified.

B) Inside the room, verification must occur matching the blood to the patient with two identifiers (name, date of birth [DOB]); verbally and against the patient wrist band.

C) The blood must not be hung before the verification has occurred. If the nurse is interrupted for something more pressing, the incoming nurse will need to re-verify that the product is correct before transfusing.

13. Perform the 2-RN bedside checklist:

A) Verify the provider's order

B) Verify that the consent has been signed by the patient (or appropriate representative).

C) Check the blood bag number, expiration date, blood type and Rh.

D) Two RNs must identify the patient at the bedside by asking the patient for his or her name and date of birth. This is compared to the patient's armband and blood Transfusion Card.

E) Transfusion card will be completed in its entirety by two RNs/GNs and upon completion returned immediately to the lab,

F) *Wear gloves when handling the blood bag.*

(ALJD 8:31-9:7; GC Exh. 3 pgs. 5-6).

On Respondent's blood transfusion card, there are boxes for two RNs to check off the following items:

- Physician order verified
- Informed consent obtained

(GC Exhs. 2, 5).

Under these boxes the form states 'below information must be verified at patient bedside,' then continues with boxes for two RNs to check off:

- Patient name, dob on bracelet agrees with those on tag
- Unit type and Rh donor # on this form are the same as on container
- Unit is not outdated
- Date and time started

(GC Exhs. 2, 5).

As the ALJ noted, Respondent's blood transfusion policy and its blood transfusion card are inconsistent, specifically relating to what information needs to be checked and where. (ALJD 10:7-19, 28:36-38. GC Exhs. 2, 3, 5). The record is replete with witnesses testifying inconsistently as to how they perform blood transfusions, or how they performed them in the past. (ALJD 24:20-29:8; Tr. 73, 166-67, 175, 344, 348, 356, 365, 368-69, 1781, 1802, 2766-67, 2799). Further, as the ALJ noted, witnesses testified that different departments of the hospital followed different procedures when administering blood transfusions. (ALJD 27:18; Tr. 1781, 1765-66).

C. Respondent's pretextual investigation

The ALJ found that Respondent's investigation in this case was quite abnormal. For the first time, it twice initiated a peer review committee to determine disciplinary action. Instead of calling on its director of patient relations, Jacqueline Barr, whose job is to respond to patient complaints, Respondent appointed Karen Ames, chief patient safety officer and director of quality and patient safety, to personally oversee the investigation, even though Ames does not normally conduct investigations, did not appear to have the basic medical knowledge to make assessments into the validity of certain claims, and has only directly investigated a handful of dissimilar cases before. (Tr. 800-05, 807-09, 2878, 3598-99). Respondent drafted Marshall's termination letter just five days after the incident and before launching its predetermined investigation. (GC Exh. 22, 27). It ignored the interviews of four nurses who admitted that the

blood transfusion policy was not always followed. (GC Exh. 9, Tr. 913, 975, 978, 1082-84, 1117-18, 1134, 1163, 1705-06, 1727). Respondent also prohibited its quality project manager, Anna Bartel, from performing a covert audit to monitor employees' compliance with the blood transfusion policy. (ALJD 24:6, Tr. 3408-10, GC Exh. 74). Respondent's actions were anomalous and did not fit with its previous responses to violations of its blood transfusion policy. (ALJD 50:13-27).

Respondent's well-documented history of anti-union animus coupled with widespread confusion about, and non-compliance with, its internally inconsistent blood transfusion policy and its openly pretextual investigation led the ALJ to correctly find that Respondent violated Sections 8(a)(1) and (3) of the Act.

I. The ALJ made sound credibility determinations (Respondent's Exceptions 10, 11, 14, 15, 24, 25, 26)

Respondent excepts to many of the ALJ's credibility determinations. The ALJ found the statements of Ames, Debra Raupers (Respondent's vice president of patient services and chief nursing officer), and Linda Crumb (Respondent's assistant vice president of patient services and acting ICCU director)—that they were very upset by the September 11 incident—to be contrived. She also found the testimony of Dr. Daniel Sudilovsky, Respondent's chairman of pathology and director of laboratories, regarding the possibly dire effects the September 11 incident to be partially contrived. The ALJ did not credit former ICCU director Shawn Newvine's testimony about the consistency with which RNs performed the 2-RN check during his tenure at Respondent's facility. Nor did the ALJ credit Raupers' testimony that she found no evidence that employees other than Marshall and Lamb violated the blood transfusion policy. The ALJ also failed to credit ICCU charge nurse Scott Goldsmith, who failed to recall important

events and whose nervousness manifested itself in twice knocking over the microphone on the witness stand.

The ALJ's credibility resolutions depend on myriad factors, including the context of the witnesses testimony, "the weight of the respective evidence, established or admitted facts, inherent probabilities, and reasonable inference which may be drawn from the record as a whole." *RC Aluminum Industries*, 343 NLRB 939, 939 n. 2 (2004). It is well established under Board law that an ALJ's credibility resolutions are precluded from reversal unless "a clear preponderance of all the relevant evidence" convinces the Board that they are incorrect. *Standard Dry Wall Products, Inc.*, 91 NLRB 544, 545 (1950), *enfd.* 188 F.2d 362 (3d Cir. 1951); *American, Inc.*, 342 NLRB 768 (stating that the Board relies on the judge, as the finder of fact, to make determinations regarding the credibility of witnesses whose testimony is in conflict). It is well-settled that "nothing is more common in all kinds of judicial decisions than to believe some and not all" of a witnesses testimony. *Jerry Rice Builders*, 352 NLRB 1262, 1262 fn. 2 (2008) (citing *NLRB v. Universal Camera Corp.*, 179 F.2d 749, 754 (2d Cir. 1950), revd. on other grounds 340 U.S. 474 (1951)); *see also J. Shaw Associates, LLC*, 349 NLRB 939, 939-40 (2007).

The ALJ's credibility determinations were reasonable and well-supported by the record evidence, and should be upheld. The ALJ found that Raupers, Ames, and Crumb's testimony about how upsetting they found the September 11 incident contrived for several well-articulated reasons. First, the ALJ noted that although Raupers, Ames, and Crumb all expressed outrage over Marshall's apparent failure to adequately assuage patient SF's concerns, Respondent intentionally omitted information that showed that Marshall had actually attempted to explain to SF that the blood had been verified by two nurses. (ALJD 16:17-19; Tr. 1229, 1247; R. Exh. 20(b)). Next, Raupers instructed Ames to investigate the incident. This was already out of the

ordinary as Ames' job is to oversee the investigations undertaken by the employees in her department, not to mention the fact that as a patient complaint, the entire issue should have been handled by Jacqueline Barr, director of patient and customer relations. (ALJD 15:39-45; Tr. 2878, 3049). As the ALJ noted, not only did Respondent not proceed in the normal way by having Barr handle the patient complaint, it called Barr as a witness, did not ask her any questions about the September 11 incident and patient complaint, and strenuously objected to Counsel for the General Counsel's attempts to question her about the typical patient complaint process and why that process was not used for patient SF's complaint. (ALJD 15:42-16:2; Tr. 2905).

According to Raupers and Ames, Ames was put in charge of the investigation because the incident constituted a "serious safety event." (ALJD 15:42-43; Tr. 2878). However, Respondent's own policies define a serious safety event as one that actually results in permanent harm to the patient. (ALJD 16:26-32; Tr. 2702, R. Exh. 55). Clearly, Respondent misclassified the event as the most serious type of event possible. Even the lesser classifications of "precursor event" (an event which actually reaches the patient but causes no harm) or "near miss" (a situation that could have, but did not, result in an adverse effect due to timely intervention or chance) do not apply to this situation, where the patient was not actually ever in danger of receiving the wrong blood. (ALJD 16:28-32; Tr. 2703-2704; R. Exh. 55). The ALJ also noted that Ames' department had investigated several instances where actual harm *did* occur, yet Ames testified that she had never been involved in a case with such a high risk level as the September 11 incident. (ALJD 16:39-43; Tr. 836).

Finally, the ALJ compared Raupers, Ames, and Crumb's reaction to the September 11 incident where the ringleader of the nascent union organizing campaign was involved, with their

response to a similar blood transfusion incident in 2012 in which the wrong blood actually entered a patient's room, was hung, and was spiked before the error was discovered. There, Ames herself refused to classify the event as a "serious safety event" because no harm came to the patient. (ALJD 40:3-4; GC Exh. 53(c)). Moreover, two of the three nurses involved in the incident received no punishment whatsoever. (ALJD 41:1-6; GC Exh. 53(b)). While the third and lead nurse in that situation did leave Respondent's employ, she had a robust history of disciplinary actions and was suspected of diverting narcotics, which, Respondent's own witness testified, factored into the decision to discharge her. (ALJD 40:8-35; Tr. 2365, 2428-31, 2439-40, 2447-49; R. Exh. 35; GC Exh. 58).

Taking into account the contrast between Respondent's reactions in 2012 and 2016, its misclassification of the event as a "serious safety event," Raupers' direction that Ames directly conduct the investigation, the fact that Respondent failed to have the person in charge of patient complaints respond to the patient complaint and then prevented her from testifying as to one of her central job responsibilities, and omitted information showing that Marshall actually did try to ease patient SF's concerns, the record amply supports the ALJ's determination that Raupers, Ames, and Crumb's testimony as to being very upset with the severity of the situation was contrived. Respondent's Exception 10 should be dismissed.

Respondent also excepts to the ALJ's credibility determination with regard to Sudilovsky's testimony on the possible dire effects of the September 11 incident. Sudilovsky testified that Marshall and Lamb's failure to follow the blood transfusion protocol could have resulted in loss of licensure for the hospital. (ALJD 31:28-30; Tr. 1962). However, as the ALJ pointed out, the hospital is only required to report incidents where the wrong blood actually reached the patient. As that did not happen in this case, no mandatory reporting function was

triggered. (ALJD 31:29-32; R. Exh. 55). The ALJ therefore found that Sudilovsky's testimony that the incident could have led to loss of licensure was partially contrived. The ALJ's credibility determination should be upheld because Sudilovsky's testimony is not actually correct. The ALJ is not required to credit testimony that is demonstrably wrong. Respondent's Exception 11 should be dismissed.

Respondent further excepts to the ALJ's decision not to credit the testimony of Shawn Newvine. The ALJ found that Newvine seemed overly rehearsed in his testimony that he had never failed to comply with the 2-RN check policy in his time at Respondent's facility, and that no nurse he ever worked with ever failed to comply with the policy either. (ALJD 26:fn. 29). Newvine's confident assertions that neither he nor anyone he worked with ever broke this particular rule were undercut by his inability to actually remember the names of any RN with whom he had ever performed a blood transfusion with at Respondent's facility. (ALJD 26 fn. 29; Tr. 2468-69). Nor could he remember other, similar details, such as how many nurses are required to take narcotics out of a machine (two). (ALJD 26 fn. 29; Tr. 2475). Not only was Newvine's confident testimony about blood transfusions at odds with his uncertain testimony about other details of working at the Respondent's facility, it was also directly contradicted by the credible testimony of multiple RNs who testified that they had in fact performed blood transfusions with Newvine when he was their supervisor, and that when acting as the secondary nurse, Newvine himself had engaged in the same behavior as Marshall and Lamb – Newvine and the primary nurse would check the blood together at the desk, and then the primary nurse would go alone into the patient's room to do the bedside check and start the transfusion. (ALJD 26:20-33; Tr. 90, 92, 186, 362-65, 368-69).

Based on the credible testimony of multiple other witnesses, and because his confident and seemingly well-rehearsed testimony on the blood transfusion process was at odds with his uncertain testimony regarding who he actually performed those transfusions with, as well as other aspects of Respondent's policies, the ALJ determined that Newvine's testimony on the blood transfusion issue was too good to be true. (ALJD 26:fn. 29). Because it is supported by the weight of the record evidence, the ALJ's credibility determination on Newvine's testimony about blood transfusions should be upheld, and Respondent's Exception 24 should be dismissed.

Respondent also excepts to the ALJ's refusal to credit Raupers' testimony that she found no evidence of other employees violating the blood transfusion policy. Again, the ALJ's credibility finding should be upheld. (ALJD 22:31-32). It is supported by the weight of record evidence. Raupers was presented with the results of Ames' interviews with four RNs, all of whom indicated that there were in fact instances where the blood transfusion policy was not followed. (ALJD 20:42-21:39; ALJD 22:31-44; Tr. 913, 1081-82, 1705; R. Exh. 9). The ALJ also noted that in Raupers' evaluation, she was complimented for her handling of the blood transfusion issue in the context of the "labor organizing threats we faced this year." (ALJD 33:32-40, GC Exh. 75). The ALJ noted that Raupers' demeanor also influenced her decision not to credit that portion of her testimony, noting that she was nervously rubbing a wooden cross while on the stand. [5] That sort of attention to demeanor and detail is impossible for the Board to replicate, thus, the Board will not overturn an ALJ's credibility determination unless "a clear preponderance of all the relevant evidence" convinces the Board that they are incorrect.

[5] The ALJ was generous when she described Raupers' wooden cross as "small" as it appeared to be over half a foot long. The cross only appeared during Raupers' testimony, despite the fact that she was in the hearing room every day, and it disappeared when she got off the stand.

Standard Dry Wall Products, Inc., supra. Here, the weight of the relevant evidence supports the ALJ's credibility determination. Respondent's Exception 25 should be dismissed.

Again, Respondent makes an uninspired argument that the ALJ should not have discredited Scott Goldsmith for various reasons unsupported by the record evidence. However, the ALJ discredited Respondent's witnesses for tangible and rational reasons. For example, the ALJ's credibility resolution that Scott Goldsmith's nervousness was uncharacteristic of a person testifying honestly on their employer's behalf is reasonable. Goldsmith was the only witness who repeatedly knocked over the microphone, despite it being repositioned away from him, and the ALJ found this to be a physical manifestation of his "uneasiness." (ALJD 11 fn. 17). The ALJ's reliance on her observations of the witnesses is a reliable way to form a basis for discrediting witnesses. Moreover, the ALJ cited numerous other reasons for discrediting his hesitant and vague testimony. The ALJ accurately found that "Goldsmith repeatedly stated that he was unable to remember with accuracy" crucial events after the incident. (ALJD 11 fn. 17, Tr. 2942, 2949, 2968-69). His inability to recall these situations, despite being prepped and knowing that management was keenly interested in the circumstances at issue were weighed against him. (ALJD 11 fn. 17). It is well established that the Board does "not overrule a Trial Examiner's resolutions as to credibility except where the clear preponderance of *all* the relevant evidence convinces us that the Trial Examiner's resolution was incorrect." *Standard Dry Wall Products, Inc.*, 91 NLRB at 545. Here, even Respondent admits that at least some evidence supports the ALJ's determination. In its brief, Respondent admits that there are "minor discrepancies" between the testimonies of the witnesses. (R. Br. 24). Respondent also fails to mention the other bases for which the ALJ discredited its witness. This is enough to overcome any attempt by

Respondent to convince the Board that the ALJ's credibility resolutions in this regard were incorrect. Thus, Respondent's Exception 26 should be dismissed.

Importantly, the ALJ did not discredit all of Respondent's witnesses. In fact, she credited Respondent's witness, Star York, the patient's sister. The ALJ's observation about patient SF's state of mind that Respondent found to be so "insulting" actually arose from York's testimony. Respondent, in its redirect examination, asked York about her sister's competency at the time of the incident. York reminded the court that her sister was "critically ill and in the ICU and suffered, you know." (Tr. 519). She answered Respondent counsel's question by stating that her sister even admitted that she was vulnerable and "as far as her competency, you know, I wouldn't say she was right up where she normally would be." (Tr. 519). York could not recall what or how much medication her sister had received that day. (Tr. 525-26). York even shared with John Turner later that her "sister was in a very scary place." (ALJD 13:17-18, Tr. 457). The patient's emotional state is relevant because Respondent relied heavily on the patient's complaint, which was her recollection of the events in question. (R. Exh. 6). The patient's mental state affects her memory of the incident and her interpretation of the conversation she had with Marshall. York's testimony allowed the ALJ to recognize that, given the patient's delicate health situation and her admitted vulnerability, it would not be unreasonable to question her memory considering the nature of her circumstances.

Also, contrary to Respondent's contentions, the ALJ never even insinuated that the complaining patient wanted Marshall and Lamb fired. (R. Br. 24). Rather, the ALJ correctly determined that Respondent used the written complaint, which it solicited, as a convenient excuse to rid itself of the lead union organizer and another union supporter in order to discourage union activity at its facility. Tellingly, York testified that she complained about numerous issues

to two separate administrators about her sister's care, yet the only issue that Respondent followed up on was the one relating to Marshall. (Tr. 461-63, 503, 505-06). For the foregoing reasons Respondent's Exception 14 should be dismissed.

Respondent further asks that the ALJ's decision be reversed because it claims that the ALJ found that Marshall's "dismissive attitude" toward the patient was not a basis for discipline. The ALJ made no such finding. To the contrary, the ALJ failed to find that Marshall was dismissive at all. Rather, the ALJ found that Marshall appropriately addressed the patient's concerns. Based on the record evidence, the ALJ found that "[a]s she was initiating the transfusion patient SF asked her if she had checked the blood, Marshall testified that she responded, 'I have absolutely checked the blood.' – 'I have checked it out at the nurse's station with another nurse.' (Tr. 1229.) Marshall testified that she believed she had addressed patient SF's concern because she did not bring the matter up to her again." (ALJD 12:10-12, Tr. 1231-33). The record is devoid of evidence demonstrating that Respondent has previously disciplined an employee as a result of a patient's complaint about a staff member's dismissive attitude. (ALJD 16:15-17). Contrary to Respondent's belief, it is Respondent's burden to demonstrate that it would have disciplined the discriminatees absent their union activity. As Respondent presented no such evidence, it failed to meet that burden and the ALJ's finding in this regard was appropriate and Exception 15 should be denied.

II. The ALJ's findings about the September 11, 2016 incident were proper and fully supported by the record

Respondent excepts generally to the ALJ's findings surrounding the September 11 blood transfusion incident. However, the ALJ's findings are fully supported by the record. The ALJ found that there was widespread confusion over the requirements of the blood transfusion policy, including whether two-RNs were required to perform the bedside check. She found that

Respondent chose to ignore evidence of the confusion and instead, relied on Ames' interviews with ICCU RNs, where her own notes are inconsistent with her interpretation of the interview. The ALJ then found that Respondent's claim that Marshall and Lamb's actions were so egregious as to warrant termination was a pretext for ridding itself of Marshall, a vocal union supporter, and that Respondent's actions in terminating them were not supported by past practice. Further, the ALJ found that Respondent treated other violations of the blood transfusion policy less seriously than the September 11 incident, even when those incidents were more likely to cause harm to the patient.

A. The ALJ correctly found that Respondent ignored widespread confusion about and flawed application of the blood transfusion policy (Respondent's Exceptions 1-7)

The ALJ correctly found that there was confusion about the two-RN bedside verification requirement. RN Mary Day testified that the failure to have a second RN present at the bedside check was "such a common practice that no one incident stands out." (ALJD 24 fn. 26; Tr. 186). In Ames' own interviews with four ICCU RNs, Terry Ellis testified that she "can't say that there has never an occurrence when [the check] is done away from the bedside such as at the nurses' station" and that "maybe there needs to be more education on what to do," Joan Tregaskis stated that she "can't speak to if [the two-RN bedside check] happens all the time with other nurses," and Anita Tourville-Knapp stated that though she does perform the two-RN bedside check, "there may be an occasion where it is not" done, for example "if they are really busy and you are grabbing another nurse to do the check." (R. Exh. 9). Ananda Szerman told Ames that she "recently heard about the need to do [the check] at the bedside." (R. Exh. 9). When Ames asked her if she ever did the check away from the bedside, according to Ames' own notes, "she gestured to the nurses' station area and stated 'you can still see the patient.'" (R. Exh. 9).

Szerman also told Ames that RNs did not document on the transfusion card whether they did the two-RN bedside check at the bedside versus at the nurses' station. (R. Exh. 9).

Tregaskis, Tourville-Knapp, and Szerman all testified at the hearing that they told Ames that they do not always perform the bedside check with two RNs.[6] (ALJD 21:1-39; Tr. 913, 1081-82, 1123-24, 1705, 1735). Szerman testified that she knew why Ames was questioning her, and told Ames that "I did today because they reminded us to do it with two nurses at the bedside…but normally I don't always do it that way," Tourville-Knapp, who was unaware of the reason for Ames' questions, said "I always check at the desk in front of the room of the patient, and do all the pertinent checks, but may not have the second nurse go in the room," and Tregaskis, who also knew why Ames was questioning her, said that "there are times when it's really crazy and it just can't be checked in the room." (ALJD 22:11-25; Tr. 913, 1082-83, 1705).

The ALJ's findings in regard to the widespread violation of the two-RN bedside check requirement are clearly supported by the record. And, in light of the foregoing, the ALJ did not err in crediting Marshall's testimony that because having only one RN perform the bedside check was such a routine and common practice in the ICCU, she did not recall that the policy actually required it. (ALJD 12:35-38).

The ALJ was also correct when she found that Respondent willfully ignored the widespread failure to comply with the policy. After interviewing the four ICCU RNs about this practice, Ames passed her notes about the interviews along to Raupers. (ALJD 20:46-21:29; R. Exh. 9). Somehow, despite the RNs statements as recorded by Ames, Respondent came to the conclusion that there was no evidence that RNs other than Marshall and Lamb ever failed to perform the two-RN bedside check. (ALJD 22:44-23:3; Tr. 3342, 3487-88). Ames did not

[6] RN Terry Ellis was not called as a witness by any party at the hearing.

interview any of the other ICCU RNs, or any other RNs throughout the facility about their practices. Raupers and Ames did not ask any other RNs about their blood transfusion practices until after Lamb and Marshall had been suspended, when they both attended a mid-shift safety huddle at which they read aloud patient SF's complaint, discussed the September 11 incident, emphasized the two-RN bedside check requirement – and then asked staff to report any other instances they were aware of where the two-RN check had not been performed. (Tr. 1159, 3535-36); GC Exh. 73). As may be expected, no RNs volunteered any information at that point. (ALJD 33:18-33:25).

Even more tellingly, on September 30, 2016, quality project manager Anna Bartel, who worked under Ames, e-mailed Ames the following message:

> Starting 9/30/16, the PI department will observe random blood transfusions and audit compliance per the policy. Findings will be reported to Deb Raupers, Linda Crumb, and Karen Ames. We will attempt to make these audits covert….

(GC Exh. 74).

Bartel also noted in her e-mail that she did not feel the current blood transfusion policy training method was sufficient and that Respondent should make it a yearly training. Finally, she noted that Respondent should verify that all units were trained on the blood transfusion policy. Ames responded by email on October 4, 2016. The full text of her e-mail was:

Don't do anything yet.

(ALJD 24:6, Tr. 3408-10; GC Exh. 74). Indeed, not only did Bartel not do anything at that point, she was never permitted to do anything to act upon her suggestions.

Between Ames' disinclination to interview more than four ICCU RNs, Respondent's failure to further investigate the RNs responses to Ames' questions or interview any other RNs, and Ames' instruction to Bartel not to implement an audit to see whether RNs were actually

complying with the blood transfusion policy, the ALJ would have been hard-pressed to come to any conclusion other than the one she reached: that Respondent chose to ignore the red flags indicating that compliance with what it so impassionedly argues is the critical portion of its blood transfusion policy might have been incomplete. Additionally, Respondent's decision to rely only on Ames' notes regarding the four RNs she interviewed, instead of either interviewing more RNs or allowing Bartel to proceed with the covert audit, was unreasonable under the circumstances. If Respondent was truly as concerned as it claims about the possibility that RNs were violating the blood transfusion policy, and given that, despite Respondent's claims, none of the four RNs interviewed by Ames actually said that nobody ever violated the policy, Respondent had no reason to cut short its investigation other than the fact that looking farther into the issue might undermine its ability to get rid of Marshall.

Further evidence that Respondent's outrage over Marshall and Lamb's conduct was pretextual, and that the ALJ was correct in so finding, comes from Respondent's past practice. As discussed below in section III(B), Respondent does not discipline RNs who fail to properly medicate patients before administering a blood transfusion or who fail to adequately monitor patients for adverse reactions to blood transfusions. But more illuminating is a comparison of Respondent's response to the September 11 blood transfusion with its response to the October 2012 "near miss" situation. In October 2012, three RNs participated in a blood transfusion. RN Seth Mead went to the blood bank and attempted to get bags of blood for two different patients. The blood bank would only release one bag to him at a time. Mead took the bag for patient B and brought it up to the floor, where he accidentally gave the bag to RN C.R., who was the nurse for patient A. Mead then went back to the blood bank, got the other bag of blood, and brought it

back to the floor, at which point he realized that he had given C.R. the wrong bag of blood. (ALJD 39:20-39, Tr. 2537-39).

In the meantime, C.R. had asked RN Nathan Newman to be the secondary nurse on the blood check. Without doing any checks at the nurses' station, C.R. and Newman brought the blood intended for patient B into patient A's room. C.R. hung the bag and had even spiked it, before indicating to Newman that they should perform the checks. (ALJD 39:39-43; Tr. 2508). Before they did so, Mead entered the room and told them they had the wrong blood. The bag was removed and their supervisor, Crystal Chaffin, was alerted immediately. (ALJD 39:44-47; Tr. 2355-63). As noted elsewhere, and as Ames stated in an e-mail at the time, the incident was not classified as a 'serious safety event' because no harm came to the patient. However, Ames noted that it was 'a huge near-miss.' (GC Exh. 53(c)).

Two of the three RNs, Newman and Mead, were not disciplined as a result of the blood transfusion error. At the time, Respondent felt that a debriefing for the two of them would be sufficient and that it would not be fair to "beat up on them" any further. (GC Exh. 53(b)). The third RN, C.R., left Respondent's employ, although it remains unclear whether she was discharged or resigned. (ALJD 40 fn. 35; Tr. 2365). However, contrary to Marshall and Lamb who had excellent performance evaluations and no disciplinary action to speak of (aside from previous unlawful discipline), the reasons upon which Respondent discharged C.R. were bountiful. They included: overdosing a patient on narcotics, signing excessive, non-prescribed narcotics out of the medication dispenser without a witness (as required by Respondent's policy), failing to document narcotics in a patient's medical record, and failing to document patient care in a patient's medical record. (GC Exhs. 56, 57, 58). As her supervisor Chaffin testified, it was

because of these incidents as well as the blood transfusion incident that Respondent decided to discharge C.R. (ALJD 40:8-17; Tr. 2365, 2428-31, 2449; GC Exhs. 56, 57, 58).

Despite the fact that it was a near-miss, Respondent did not initiate any investigation into what went wrong until Dr. Sudilovsky specifically requested one. (ALJD 40:37-41; GC Exh. 36). Upon his insistence, Respondent performed a Root Cause Analysis (RCA) and a Failure Mode Effect Analysis (FMEA) which set forth the procedure as understood by the participants, and then looked for places in the procedure where failures could occur, rated the severity of the possible failures, and attempted to develop processes that would eliminate the more likely failures in the future. (ALJD 40:41-43; Tr. 2364, 2612, 2627). This investigation led to an overhaul of Respondent's blood transfusion policy and the institution of a two-tiered check, one at the nurses' station before the blood entered the patient's room; another at the patient's bedside. (ALJD 41:11-14; Tr. 2627).

Respondent's investigation to the September 11 incident, discussed infra in section IV(A), was markedly different. Comparing the outcomes of the two investigations, it becomes apparent that in 2016, Respondent seized the opportunity to rid itself of the most vocal union supporter at its facility. Respondent did not conduct either the RCA or the FMEA as it had in 2012, despite ICCU RNs telling Ames that they did not always comply with the policy. (Tr. 913, 1081-82, 1123-1124, 1705, 1735; R. Exh. 9). Nor did Respondent look further into whether the non-compliance was widespread. It prevented Bartel from implementing the covert auditing program that would have shed more light on RNs compliance with the policy. (Tr. 3408-10; GC Exh. 74). Respondent sent Crumb on the wild goose chase of looking at records that would not reflect whether or not RNs had actually complied with the policy. (Tr. 3082-84; GC Exh. 33). It drafted a termination letter for Marshall (but not for Lamb) in advance of even meeting with her

to hear her version of events. (Tr. 1013; GC Exhs. 22, 27). After Marshall and Lamb were terminated, Respondent sent an unprecedented system-wide email informing its staff that the most prominent union supporter was gone. (ALJD 35:8-36:38; Tr. 1777; GC Exhs. 7, 20, 70). And, most importantly, Respondent discharged Marshall and Lamb, even though according to its own classifications, their actions did not even rise to the level of the 'near-miss' that resulted (among other problems) in C.R.'s discharge. (Tr. 2702-04; R. Exh. 55). The ALJ's finding that Respondent's expressed outrage at Marshall and Lamb's actions was a pretext to rid itself of the most vocal union supporter at its facility was proper.

As demonstrated by the foregoing, the ALJ's findings with regard to the September 11 blood transfusion incident, and Respondent's reaction to it, were sound, supported by the record, and should be upheld. The ALJ was correct in finding that Respondent violated Section 8(a)(1) and (3) of the Act by suspending and discharging Marshall and Lamb. Respondent's Exceptions 1-7 should be dismissed.

B. The ALJ correctly recognized that Respondent treated the September 11, 2016 incident differently than other violations of the blood transfusion policy (Respondent's Exception 8)

Respondent argues that the ALJ erroneously concluded that "every violation of the blood transfusion policy should be treated identically, specifically disregarding that the two-nurse bedside verification procedure is the final and most critical safeguard that ensures the proper blood product is used, and that because it is the final safeguard from instant death, such practice is taught in nursing school, is established in national practice, and used by all nurses who testified and at the previous employers of those nurses who testified on the subject." (Respondent's Exception 8, pg. 2). Respondent's slightly histrionic language presumably

constitutes an exception to the ALJ's finding that it treated other violations of the blood transfusion policy less seriously than the September 11 incident.

As the record reflects, the ALJ's finding in this regard is correct. For example, a hospital aide who usually worked in the ICCU but was working on the short stay surgical unit saw two RNs check blood at the nurses' station and then enter the patient room without taking the chart in with them. (Tr. 312-14). According to the transfusion policy, RNs are required to verify that the patient consent form is in the file at the patient's bedside. (GC Exh. 3). Instead of finding that the RNs had violated the policy, unit director Bernice Miller noted that they "followed protocol" and indicated that failing to take the chart into the room did not violate policy because different units had different ways of doing things. (ALJD 37:36-46; GC Exh. 4). Additionally, RN Jackie Thompson testified that she was performing a blood transfusion with her manager Crystal Chaffin in about December 2016 or January 2017, when Chaffin informed her she had been violating the protocol by only checking the order and consent forms at the nurses' station before going into the patient's room. (Tr. 1783-86). Thompson admitted that she had been violating the policy. No disciplinary action was taken against her. (ALJD 38:23-32; Tr. 1814-16).

In addition to these examples, the 2012 incident – where the wrong blood actually did enter the patient's room, was hung, and spiked, before the error was caught – resulted in an investigation and update of the blood transfusion policy, but did not result in any discipline of two of the three nurses involved, as Ames did not want them to "feel beaten up on." (GC Exh. 53(c)). As discussed elsewhere, the one RN who actually left Respondent's employ had a history of disciplinary actions and was already suspected of diverting narcotics. (Tr. 2365, 2428-31, 2449; GC Exhs. 56, 57, 58).

Finally, incident reports from other blood transfusions at Respondent's facility show over a dozen instances since 2012 where RNs failed to give patients the necessary pre-medication before a blood transfusion (patients are given medications such as Benadryl or Tylenol before the transfusion in order to help prevent reactions to the new blood), or failed to record a significant change in a patient's vital signs (blood pressure, heart rate, or temperature) that could have signified the onset of a serious reaction or a possible future serious reaction to subsequent transfusions. (GC Exhs. 10-13). In each case, the incident report notes that the reaction or possible reaction did not cause serious harm, and the RN in question was re-educated, not disciplined. (ALJD 44:26-35, GC Exhs. 12-13).

Respondent argues that having one RN perform the bedside check instead of two is the most serious violation of the blood transfusion policy that could possibly take place, because the bedside check is the last check that the blood is going to its intended recipient before it is administered. (R. Br. 19; Tr. 1863-65). There is no question that administering the wrong blood to the wrong patient will very likely cause irreparable harm, even death. It is not disputed that checking the blood at the bedside is an important component of the blood transfusion policy. What is disputed – what the record shows, the General Counsel proved, and the ALJ correctly found – is that because of who was involved, Respondent treated this violation of the blood transfusion policy different than any other violation of which it had ever become aware. Specifically, Respondent used this error as an excuse to get rid of Marshall, an employee it had already demoted and disciplined because of her vocal support for a union. To cover its tracks, Respondent discharged Lamb as well, even telling her that Respondent wished it could treat her differently than Marshall. (ALJD 34:33-35; R. Exh. 26(a) and (b)). In response to the 2012 blood transfusion incident, Ames sent an email stating that "Yes, this is a huge hear miss. It

would not actually be classified as serious safety event as there was no patient harm." (ALJD 40:3-4; GC Exh. 53(c)). Apparently, according to Respondent, an incident in which the wrong blood entered a patient's room, was hung, and was spiked, though not administered, is less serious than an incident where after two nurses thoroughly check the correct blood at the nurses' station, only one nurse performed the bedside check before the blood is administered to a patient. The ALJ was correct when she found that Respondent treated this violation of the blood transfusion policy differently than other violations for which RNs were simply corrected or re-educated, not disciplined or discharged. Respondent's Exception 8 should be dismissed.

C. The ALJ was correct in finding that because the right blood was verified for the right patient, no "event" would have reached the patient (Respondent's Exception 9)

Respondent excepts to the ALJ's conclusion that because the right blood was verified for the right patient, the patient was not at risk in this particular situation. The ALJ's actual finding was that because the right blood was verified for the right patient, there was never an "event" that could have reached the patient. (ALJD. 16:31-32). As the ALJ noted, and despite Respondent's claims to the contrary, the September 11 blood transfusion incident was not a serious safety event, precursor event, or near miss as defined by Respondent. (Tr. 2702-04). Respondent's own policies define a "serious safety event" as one that actually results in permanent harm to the patient and involves a deviation from a standard. (Tr. 2704). A "precursor event" is one that actually reaches the patient, and may or may not cause harm. (Tr. 2703). A "near miss" is a situation that could have, but did not, result in an adverse effect due to timely intervention or chance. (ALJD 16:26-32; Tr. 2702; R. Exh. 55).

Under Respondent's classification, the September 11 blood transfusion incident would not qualify as any of the three classifications. Because no permanent harm was done to patient

SF, it is not a "serious safety event." If, as in *Jackson Hospital*, discussed infra, Lamb and Marshall had administered the wrong blood but the patient was not harmed because that blood happened to be a match, this situation could well have been classified as a "precursor event" – but they had the right blood, which they knew, because they checked it. Because Marshall and Lamb in fact did have the correct blood for patient SF, this was not a situation in which doing a one-RN instead of two-RN bedside check could have resulted in an adverse consequence, but did not due to luck or timely intervention, so it was not a "near miss." The ALJ's finding that because the right blood was verified for the right patient, there was not an event that could have reached the patient, is correct. Respondent's Exception 9 should be dismissed.

D. The ALJ appropriately distinguished *Jackson Hospital Corp.* (Respondent's Exception 12)

Respondent excepts to the ALJ's finding that *Jackson Hospital Corp.*, 355 NLRB 643 (2010) is distinguishable from the instant case. According to Respondent, the ALJ determined that *Jackson Hospital* did not apply because patient SF was given the correct blood and therefore was not at risk in this particular situation. Once more, Respondent mischaracterizes the ALJ's findings.

In *Jackson Hospital*, the patient who was actually given the wrong blood during a blood transfusion suffered no harm because, by sheer luck, his blood was compatible with the blood intended for another patient. In that case, the blood bank supervisor selected the incorrect unit of blood and she and the primary nurse somehow mistakenly verified the information at the blood bank. Next, the primary and secondary nurses mistakenly verified the information at the nurses' station. Finally, only the primary nurse entered the patient's room, and she failed to check the patient's ID bracelet and check it once more against the blood. As soon as the CEO found out what had happened, both the primary and secondary nurses, as well as the blood bank supervisor

were placed on suspension. The respondent discharged all three employees shortly thereafter. 355 NLRB at 645.

As the ALJ correctly noted, the facts of the instant case are significantly different. (ALJD 50:36). First and foremost, patient SF was given the correct blood. Importantly, this was not by sheer luck. Unlike in *Jackson Hospital*, the correct blood was provided from the blood bank and, in another important distinction, was thoroughly verified by Marshall and Lamb at the nurses' station. (ALJD 50:36-39). In *Jackson Hospital*, the secondary nurse 'glanced at' the blood bag before signing off that it was the correct blood. Here, secondary nurse Lamb testified that she and Marshall checked that the blood had been ordered by a physician, and then checked the written order in the chart. They looked in the chart for the signed consent form from the patient. The two nurses checked that the unit was not outdated and that the unit type and donor number on the form matched the container. To check this, one of them read off the information from the blood bag, and the other verified that it matched the transfusion card. Then they checked that the patient name on the transfusion card matched that on the order and consent. (Tr. 1226, 1236-38, 1544). They filled out the blood transfusion card as they carried out the checks. (GC Exh. 2; Tr. 1544-45). Finally, unlike the primary nurse in *Jackson Hospital*, Marshall did check the patient's wristband once she was in the room. (ALJD 50:39-40; Tr. 1228-29, 1247, 1368; R. Exh. 20(b)). Even Sudilovsky testified that he was not certain he would have taken the same position against Marshall had he been informed that she actually did verify the patient's wristband ID. (ALJD 50:40-42; Tr. 1968-71).

Respondent attempts to invest the ALJ with a cavalier attitude relative to the safety of patient SF by suggesting that the ALJ used a "no harm, no foul" standard to distinguish this case from *Jackson Hospital*. This attempt falls flat as Respondent's October 2012 near miss incident

is actually more analogous to *Jackson Hospital* than the September 11 incident, as the RNs in that situation actually brought the wrong blood into the patient's room. Respondent itself categorized the 2012 incident as a "near miss" because no harm came to the patient. By contrast, even though no harm came to the patient in the September 11 incident, Respondent classified it as a "serious safety incident," a more severe classification than a "near miss." The ALJ appropriately recognized that the distinction between *Jackson Hospital* and the instant case lies in what the RNs actually did. Here, unlike in *Jackson Hospital* and unlike in the 2012 incident, all the correct information was checked at the nurses' station, and the bedside check was actually performed by Marshall. The ALJ correctly distinguished this case from *Jackson Hospital*. Respondent's Exception 12 should be dismissed.

E. The ALJ did not err in excluding Respondent's proffered exhibits (Respondent's Exception 13)

Respondent excepts to the ALJ's exclusion of two letters from the New York State Education Department's Office of Professions. Respondent chalks the exclusion of this evidence up to the ALJ's supposed "agenda" of refusing to acknowledging evidence that did not support her predetermined theory of the case. Again, Respondent is wrong. The ALJ refused to admit the proffered exhibits because, as she clearly stated in the ALJD, "they did not constitute a final decision by [the Office of Professions] and give no basis for the determination to make that referral." (ALJD 35 fn. 20). The ALJ by excluding the letters acted well within her discretion. The Board's Rules and Regulations, Section 102.35 provides, in pertinent part, that a judge should "regulate the course of the hearing" and "take any other action necessary" in furtherance of the judge's stated duties as authorized by the Board's Rules. Thus, the Board affords the judge significant discretion in controlling the hearing and directing the creation of the record. *Turtle Bay Resorts,* 353 NLRB 1242 (2009) affirmed and adopted, 355 NLRB 706 (2010); *Parts Depot,*

Inc., 348 NLRB 152, 152 n. 6 (2006) (respondent failed to show judge's rulings resulted in prejudice or denial of due process). It is well established that the Board will affirm an evidentiary ruling of an administrative law judge unless that ruling constitutes abuse of discretion. *300 Exhibit Services & Event, Inc*., 356 NLRB 415, n. 1 (2010); *Aladdin Gaming, LLC*, 345 NLRB 585, 587 (2005). As demonstrated throughout her decision and the record of the hearing, there is no evidence that the ALJ abused her discretion in excluding these documents. Accordingly, Respondent's Exception 13 should be dismissed.

III. The ALJ's conclusions about Respondent's investigation were accurate

The record evidence reveals that Respondent's decision to terminate Marshall and Lamb was a foregone conclusion well before the investigation was completed. The ALJ's findings relating to Respondent's conclusory investigation were based on a thorough analysis of the extensive testimony and reasonable credibility determinations. This includes her findings regarding the patient's emotional state, Respondent's biased investigation, and Respondent's failure to apply its own "just culture" algorithm.

A. Respondent's investigation was predetermined (Respondent's Exceptions 16-19, 23)

Respondent contends that its investigation was "thoroughly conducted" and that any finding to the contrary should be disregarded. The evidence contradicts Respondent's assertion. The ALJ correctly found that there were serious irregularities in this investigation. First, that Raupers directed Ames to personally lead the investigation is suspect in and of itself. (Tr. 866-70, 2878-79). The ALJ appropriately found that, according to the comparable termination evidence, the unit director and/or manager would typically conduct the investigation. (ALJD 48:27-29). Indeed, Ames only recalled "less than a handful" of times she conducted an

investigation herself and all of those involved actual harm to the patient. (ALJD 48:29-30; Tr. 73-75).

The peer review committee meetings are also problematic. The September 11 incident was the first time in Respondent's history that a peer review committee was made a part of the disciplinary process. (ALJD 48:35-39; Tr. 1060). The peer review committee itself was convened in a manner that contravened its own policies since not all of the departments were represented (specifically, the ICCU and Emergency Department did not have representatives on the peer review committee). (GC Exhs. 15, 16; R. Exh. 59). But Linda Crumb, a supervisor specifically found to have harbored anti-union animus in the previous Board case and a main decision maker in this case, was involved in the committee meetings even though she was not on the committee. (Tr. 3139-40).When the first committee failed to reach a conclusion, it was convened a second time. (Tr. 3478, 3481). In the first committee meeting, the committee could find no evidence of wrongdoing and recommended that Respondent interview the nurses involved as well as other staff, as Respondent had not yet done so. (Tr. 3137-38; GC Exh. 68, 69). In the second session two outsiders to the committee, Ames and Raupers, were permitted to attend. At no time did they mention the employee interviews that Ames had performed at the committee's behest. (GC Exh. 68, 69). Ames and Raupers also failed to mention the information obtained from meeting with Lamb. Rather, Ames "presented the results" of her investigation by reading the patient complaint to the committee; a complaint which Respondent had solicited. (R. Exh. 6; Tr. 769, 3240, 372-73). Raupers, a committee outsider and management official, remained in the session while the RNs on the committee held rounds of open voting and discussion until consensus was reached. (Tr. 3482).

Even more critical than the spurious peer review committee meetings was Ames' attempt to interview nurses about the blood transfusion policy, at the peer review committee's request. First, she only interviewed four nurses. All four nurses explained that they did not follow the transfusion practice as prescribed. (Tr. 913, 975, 1082-84, 1705-06). Ames and Raupers testified that their investigation revealed no evidence that other RNs failed to perform the 2-RN bedside check. However, as the ALJ correctly found "Ames' own notes regarding her interviews of the other ICU RNs cannot reasonably be read to be consistent with this claim." (ALJD 49:20-21, R. Exh. 9). Second, had Respondent spoken to more than four nurses, it would have discovered that two of the most senior nurses on staff in the ICU, Mary Day and Christine Monacelli, agreed that the policy was not followed to the letter. (Tr. 72-74, 406, 589). Even Respondent's own witness, Jennifer Cole, testified that she had never noticed the "perform at bedside" line on the blood transfusion card prior to the September 11 incident. (GC Exh. 2. Tr. 952, 957, 960, 1599, 2807, 2816). Finally, when Bartel suggested observing random blood transfusions and auditing compliance with the policy, Ames curtly directed her, "don't do anything yet." (ALJD 49:27-30; Tr. 3408-10, GC Exh. 74). It was clear that Respondent had a desired outcome for the investigation, and it willfully ignored any evidence that might contradict that conclusion.

Respondent also appears to have relied on a review of completed transfusion cards to reach a conclusion that, because those cards were completed, everyone must have been following the policy. (Tr. 3082-84; GC Exh. 33). Respondent continues to fail to comprehend that without investigating further there would be no way to know, by simply looking at the cards, whether someone completed a step at the time they initialed the corresponding box. This is particularly true in light of the fact that nurses repeatedly testified that they fully completed the transfusion card before actually performing the corresponding action, and were mistaken about the policy

requirement. (ALJD 28:36-50; Tr. 2766-67, 2770, 2785, 2799, 2800). Respondent repeatedly ignores testimony that revealed that when something on the card is not fully completed, the card is simply returned to the nurse for completion and that nurse makes no indication on the card that the documentation took place after the fact. (ALJD 44:38-42; Tr. 1407-08). These cards form no reliable basis to conclude that the policy was or was not being followed by the nurses.

Raupers, the self-proclaimed main decision maker, did not interview the other ICCU nurses working during the incident, did not interview Goldsmith either time he was allegedly questioned, did not attend Lamb's suspension meeting, did not speak to Lamb at all prior to her termination, and only spoke to Marshall during her termination meeting. (Tr. 3593-94). She did, however, have an unusual meeting on October 4 that involved CEO John Rudd about the decision to terminate Lamb and Marshall. (Tr. 3561).

Finally, Respondent's actions reveal that its decision to fire Marshall and Lamb was made before it spoke to either of them. (ALJD 19:19-21; Tr. 2010-11; GC Exh. 22). Respondent continues to confuse the issues. The issue is not that it did not speak to Marshall and Lamb prior to conducting any of its investigation, but rather, that it did not speak to Marshall or Lamb before it decided to fire them. Respondent argues that the findings that it failed to contact Marshall or Lamb before it decided to fire them and the fact that Marshall knew she was under no obligation to respond to its phone calls while she was on a pre-scheduled vacation are inconsistent. They are not. The ALJ found that Respondent's excuse that it had to handle a routine audit so it could not contact Marshall *before* she left for her vacation to be a falsehood based on the other activities they engaged in during that same time period. (ALJD 49:4-6). The ALJ found that:

> …multiple steps were taken in CMC's quest to discharge Marshall during the time the audit occurred, including multiple contacts with patient SF, review of HealthStream coursework, a review of patient SF's blood transfusion history, a review of all blood transfusion incident reports since 2012, a review of transfusion cards, drafts of Marshall's discharge letter, a peer review committee meeting, instructions to ICU charge nurses to remind their RNs to perform a 2-RN bedside check, interviews of other ICU nurses, and the necessary communications amongst management officials orchestrating these actions.

(ALJD 48:45-50; 49:1). The ALJ did not fault Respondent for not contacting Marshall while she was on pre-scheduled leave, in fact the ALJ noted that Respondent did try to contact Marshall while she was away. The ALJ's finding that Marshall did not return Respondent's calls when she was away makes that clear. (ALJD 12 fn. 19).

Respondent in its brief admits that "CMC already knew that the nature of the offenses warranted immediate discharge." (R. Br. 29). If that was the case, then the termination could have been immediate. Instead, Respondent set out on a crusade to distort evidence to justify its decision to terminate Marshall and Lamb. Marshall and Lamb both worked shifts after the incident; if their acts were so abhorrent Respondent should have suspended them immediately rather than permitting them to continue to work. (Tr. 1238). Respondent drafted Marshall's termination letter early in the investigation. As the ALJ concluded based on the facts, "CMC's VP of HR Brian Forrest was unwilling to state when the decision was first made to discharge Marshall, but sometime on or before September 16, Forrest directed his secretary to draft a discharge letter for Marshall. (Tr. 2010-11; GC Exh. 22.)." (ALJD 19:19-21; GC Exh. 22, 27). The letter relied on Marshall's past disciplinary history in reaching the conclusion that she must be terminated. (ALJD 19:25-26; GC Exh. 22). However, the Board has already found Respondent's past discipline of Marshall to be unlawful. *Cayuga Medical Center*, supra slip op at 1. (ALJD 19:23-24). The ALJ appropriately discredited Brian Forrest because of his evasive

testimony and his inability to remember critical facts. (ALJD 19:32-34, 19:45-47, Tr. 1009-10, 1014-15, 1016-18, 1024, 1026). In conclusion, the ALJ found that "credible evidence supports that the decision to discharge Marshall was made by the September 16 email, before any of the steps of the 'red rule' investigation analysis had occurred." (ALJD 19:47-49). Respondent's actions make it clear that its investigation had a predetermined outcome; to rid itself of Marshall, and subsequently the union, at all costs. The ALJ's well-reasoned analysis, which relied on founded credibility assessments and an examination of the record evidence, should not be overturned. For the foregoing reasons, Respondent's Exceptions 16-19 and 23 should be dismissed.

B. The ALJ understands that Respondent ignored its own "just culture" matrix (Respondent's Exceptions 20, 21)

It is undisputed that Respondent employs a "Just Culture Algorithm" to encourage staff to report incidents for management to address safety issues. (ALJD 17:25-26; Tr. 3175; R. Exh. 58)). Respondent and the ALJ both correctly state that this matrix is used when a policy is unclear and staff would benefit from re-education. (ALJD 17:28-29; R. Br. 30). Where Respondent errs, however, is in its assessment that the incident involving Marshall and Lamb should not have resulted in re-education of the nurses.

During the hearing, the General Counsel presented over one hundred incident reports for equally or more egregious violations of policy and medical errors than the one at issue here, where employees received no discipline. (GC Exhs. 8-14). About half of these incident reports addressed blood transfusion issues, including hanging expired blood and ignoring possible transfusion reactions. (GC Exhs. 10-13). Respondent failed to present any evidence disputing the incidents, any evidence to show these employees were disciplined in any way, or any evidence to show investigations that occurred as a result of these violations. In lieu of discipline, the majority

of these employees were reeducated in accordance with the appropriate application of the just culture algorithm. (GC Exhs. 8-14; R. Exh. 58). Unfortunately for Marshall and Lamb, Respondent's obsession with ridding itself of Marshall and the union did not allow for any other outcome other than termination for what would otherwise have resulted in a simple re-education. By contrast, in response to the 2012 incident (when the wrong blood actually entered the room and was hung), Respondent who presumably has "even a basic understanding of managing a responsible healthcare institution" (R. Br. 31) decided to simply 'debrief' two of the three nurses involved in hanging the wrong blood for a patient, and flatly refused to punish them because of concerns they would 'feel beat up on.' (GC Exh. 53(b)).

The ALJ was correct in finding that re-education would have been appropriate here given Respondent's prior history. Confusion about the transfusion policy was rampant. As the ALJ appropriately found, "[i]f Ames or Raupers pursued the issue of whether the RNs truly knew and practiced the blood transfusion policy, they would have found, as became pellucid during the hearing, that the confusion and lack of full compliance with the transfusion policy was not isolated to Marshall, Lamb, and the four RNs that Ames interviewed." (ALJD 23:13-16; Tr. 72-73, 81, 344, 348, 350, 352, 356, 402-03, 576, 594-95, 1407, 1599-1600, 1606, 1802-06, 2806-07, 2766-67, 2785, 2799-2800, 2826, 2831-33). Notably, the ALJ found that, "instead of actively attempting to uncover and correct any general lack of compliance with the policy, CMC intentionally avoided such information as it would undermine their argument that Marshall and Lamb should be discharged." (ALJD 23:41-43). The best example of Respondent's willful blindness to the failures in their own policy was an email exchange between quality project manager Anna Bartel and Ames. During this exchange Bartel suggests observing random blood transfusions and auditing compliance with the policy. Ames curtly directed her not to do

anything yet. (ALJD 23: 43-51; 24:1-7; Tr. 3408-10; GC Exh. 74). The ALJ further found that "witness testimony establishes that failure to fully understand and comply with the transfusion policy was widespread." (ALJD 24:17-18).

Furthermore, the ALJ was correct in finding that Marshall and Lamb did not falsify the medical record, and even if they had under Respondent's vague definition of that term, that Respondent would not have fired them for that behavior. (ALJD 45:41). The record was devoid of any evidence that they intentionally documented the transfusion card inaccurately. The ALJ found that:

> …the record reflects that most errors made by RNs and other staff are simply errors caused by preoccupation, a lack of understanding, or a simple mistake. Yet, RN CR's repeated failure to document the wasting of narcotics, RN DN's repeated unexplainably inaccurate documentation of the crash cart checklist, aide RS's continual failure to take and accurately document vital signs that RNs repeatedly reminded her to do was determined to be falsification only after their managers attempted to re-educate them and then finally labeled their conduct falsification to discharge them. Similarly, the scanning of stickers instead of patient identification wrist bans before treating the patient has not been considered falsification.

(ALJD 45:44-48; 46:1-3; R. Exhs. 31, 33; GC Exhs. 47, 48, 50, 56, 57, 58; Tr. 2148-50; 2155-61, 2226, 2249-56).

Thus, there is no reason to believe that Marshall or Lamb would have been terminated even if they had falsified the record. The confusion about the policy is likely caused by, as the ALJ points out, the fact that the policy itself is inconsistent with the transfusion card requirements. (ALJD 10:7-25; GC Exhs. 2, 3, 5). The confusing nature of the policy coupled with the widespread misunderstanding of its application should have resulted in a re-education of the nurses rather than Marshall and Lamb being discharged. Thus, Respondent's Exceptions 20 and 21 should be dismissed.

IV. The ALJ's determination about animus and union literature was proper (Respondent's Exceptions 22, 27, 28)

Respondent argues that the ALJ improperly relied on one of Respondent's anti-union flyers as evidence of animus. Respondent misunderstands the purpose behind the ALJ's recitation of facts relating to Brian Forrest's August anti-union informational material. (R. Br. 31; ALJD 5:7-12). These facts are primarily used to demonstrate that Respondent was aware of Marshall's ongoing union activity. The material demonstrates that Respondent equated Anne Marshall with the Union when it stated that the intent was to take a "Union or Anne Marshall Focus." (ALJD 5:8-9, 47:11-13; GC Exh. 24). Marshall was undoubtedly the face of the campaign in the hospital. (ALJD 47:11-13). By unlawfully terminating Marshall, Respondent was able to halt the campaign. Respondent's statements on these materials underscore its focus on Anne Marshall during its antiunion campaign.

Critically, Respondent fails to recognize that writing can be anti-union and demonstrate animus without being independently unlawful. The Board has held that an employer's anti-union comments, while protected speech under 8(c), may nevertheless establish animus toward its employees' union activities. *See Ross Stores*, 329 NLRB 573 (1999); *Lampi LLC*, 327 NLRB 222 (1998). Here, although the flyer is not alleged as independently unlawful, it was related to Marshall and her protected activity. The subsequent communications addressed what Respondent claimed were negative impacts of union organization. Those writings are relevant to the ALJ's analysis in determining whether Respondent exhibited anti-union animus. Thus, Respondent's reliance on 8(c) as a justification for its antiunion behavior is misplaced. Notably, the ALJ does not solely rely on this one demonstration of hostility toward the ongoing union activity in its facility, but rather, her decision is replete with examples of such animus.

The ALJ appropriately relied on the extensive animus findings in the previous case. *Cayuga Medical Center at Ithaca, Inc.*, 365 NLRB No. 1. In the previous administrative hearing, one of Respondent's supervisors made specific threats to Marshall regarding her being the "ringleader" for union organizing and "promoting all this union stuff." (ALJD 18:20-22; 18:42). The Board also found unlawful Respondent's repeated targeting of Marshall, Respondent's conduct in the cafeteria, Respondent's direction to employees to cease distributing union literature, Respondent's prohibition on posting and distributing union literature, Respondent's interrogation of employees about their union activity, Respondent's threats to employees if they did not stop their union activities, Respondent's threats to employees of unspecified reprisals and job loss in retaliation for participation on union activity, and Respondent's unlawful discipline in retaliation for union activity. *Cayuga Medical Center at Ithaca, Inc.*, 365 NLRB No. 1.

The ALJ appropriately found that Marshall's union activity continued after the conclusion of the previous administrative hearing through her soliciting colleagues, hanging flyers, and passing out union material. (Tr. 1186, 1528; GC Exh. 72). As the ALJ found, "CMC management was aware of Marshall's continued union activity, and specifically, statements that she made about the union organizing campaign and related matters on social media." (ALJD 5:14-16). One example the ALJ uses is the:

> September 29 email concerning preparations for a letter in regard to the planned discharges of Marshall and Lamb that was ultimately distributed on October 6 to all of CMC's employees, physicians, and volunteers, CMC's VP of public relations John Turner tells CEO John Rudd: If Anne Marshall launches and things go public before the BOD [Board of Director] meeting, I think we should send them the attached internal communication with a slight revision. . . . Things have been quiet on the social media end.

(ALJD 5:16-21; GC Exh. 19). Respondent's anti-union animus is continuous, as is demonstrated by its email equating Marshall with the union, its continued tracking and targeting of her, and its unlawful act of removing her posted pro-union material from bulletin boards. (GC Exh. 24).

Respondent also takes exception to the ALJ's finding that it violated the Act by removing union literature from a bulletin board. Respondent mistakenly claims that the only evidence presented by the General Counsel in support of this claim was testimony by Marshall and a photograph she took of the same bulletin board which contained non-employer postings. Respondent continues to claim that Marshall's photograph was of a different bulletin board "and there should be no dispute over this." (R. Br. 33). Yet, Respondent conveniently forgets the testimony of Christine Monacelli, who clearly testified about the bulletin board's physical description, location, and presented pictorial evidence to the contrary. (Tr. 3611-14, 3615; GC Exh. 76, 77). The ALJ relied on the credible evidence when reaching her determination that Jackie Barr, the same bad actor in the previous case, had again unlawfully removed only union literature from a bulletin board which contained other non-employer material. Thus, Respondent's Exceptions 22, 27, and 28 should be dismissed.

V. The ALJ's Remedy and Proposed Order were appropriate (Respondent's Exceptions 29 and 30)

Respondent excepts to the ALJ's conclusions of law, remedy and order. However, Respondent only restates the ALJ's findings, without making any additional arguments. Respondent's general Exceptions fail to state specifically what findings or conclusions that Respondent excepts to, contrary to Section 102.46(b)(1) of the Board's Rules and Regulations. As Respondent's Exceptions 29 and 30 do not comply with the foregoing requirements, it is urged that the Board disregard them. *See* Section 102.46(b)(2) of the Board's Rules and Regulations; *Fuqua Homes (Ohio), Inc.,* 211 NLRB 399, 400 n.9 (1974).

VI. Conclusion

For all the reasons set forth above, General Counsel respectfully requests that the Board deny Respondent's Exceptions to the Decision of the Administrative Law Judge in their entirety.

Dated at Buffalo, New York, this 19th day of March, 2018.

Respectfully submitted,

/s/ Jessica L. Noto

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